ally nil, *despite* the fact that the police force was increased from 3,000 to 5,000 officers and *despite* the fact that those very same individuals had spent most of their previous adult lives in jail!

As to Dr. Sherman's statement that the pharmacological benefit of being addicted to methadone is "incidental," I might point out that methadone is not injected (hence all concomitant problems in that regard are avoided), that the desire for heroin itself is decreased, that there is no euphoriant effect (the addict is not "high," is able to drive and has normal reflexes) and that to a large extent the "kick" or other satisfaction from an injection of heroin is neutralized.

Additionally, 60-85 percent of the addicts in various programs are holding down jobs or going to school and are thus rehabilitated members of society.

No one involved in treatment programs sees methadone as a panacea. It is an effective stopgap measure. All efforts to discover other methods of treatment including non-narcotic blocking agents are being encouraged.

I wonder if Dr. Sherman is aware that there are an estimated 30,000 heroin addicts in the Los Angeles County area and that there are over 4,000 on the waiting list for the L.A. County Methadone Maintenance Program—a list which is currently increasing at the rate of 50 per week. Has he considered the feelings engendered by the horrifying necessity of the doctors in those clinics who have to send addicts away from their doors, maybe for years, in essence telling them to go back on the street and continue to get their "fixes" until their names come up on the list? I seriously doubt if Dr. Sherman has spoken to the dedicated doctors involved in the current inadequately funded programs.

Finally, in regard to the suggestion that the prospect of being able to receive methadone would serve to encourage individuals to experiment with heroin, I find this ill-conceived conjecture. Whatever the cause of heroin addiction, there is no evidence that the addict at any time rationally considers the future results of becoming addicted. If he did, he wouldn't start in the first place, since he is surely aware of the results of addiction. Further, the methadone maintenance programs have regulations regarding the length of time one has been addicted to heroin before he may be admitted (usually at least two years). Does Dr. Sherman think that a person who would not try heroin under "normal" circumstances might decide in advance to become addicted in the vague hope that after two or three years he could get on the waiting list at a methadone maintenance clinic?

I agree that drug abuse is a societal problem and will eventually require solutions beyond what medicine has to offer, but I believe that at the present time, methadone maintenance is a pragmatic solution to a medical problem.

ALFRED E. COODLEY, M.D.
Los Angeles

Free Clinics

To the Editor: I wish to congratulate you on the paper, "Free Clinics in California, 1971" [Calif Med 116:106-111, Apr 1972]. When the survey was first sent out by [Bureau of Research and Planning] the California Medical Association, a great deal of "paranoia" was created in Free Clinics as to your motives for the survey.

Some in organized medicine are opposed to free clinics and I was greatly relieved to see a fair and objective study published.

I might add that Dr. Schwartz's [material on] Free Clinics is published in expanded form in "The Free Clinic: A Community Approach to Health Care and Drug Abuse."

Also I might point out that although some free clinics are in good shape financially (The Haight-Ashbury Free Clinic just received an 8 year NIMH drug abuse treatment grant), others are not. The Long Beach Free Clinic, an excellent program prominently mentioned in the article, is in great need of funds and I hope the Long Beach Medical Society will do more to mobilize community support behind this excellent program.

DAVID E. SMITH, M.D.
San Francisco

In Defense of Corticosteroids

To the Editor: My previous contributions . . . [have had to do with] beliefs and dogmas which although, in my opinion, lacking scientific basis cause no great harm. In this instance I indict a teaching which I believe is causing tragedy for the millions of victims of diseases of hyper-immune mechanism such as asthma, arthritis, colitis and collagen disease. I refer to the emphasis placed on side effects of corticosteroid drugs.

Although moon facing, striae and easy bruising are frequent I am convinced more serious complications are improperly attributed to these drugs. When theory and deductive reasoning are held in abeyance critical appraisal of documented clinical experience indicates that:

1. Steroids *do not* cause *significant* adrenal insufficiency. Despite laboratory evidence of decreased responsiveness of the pituitary adrenal axis, documented cases of deaths attributable to adrenal insufficiency and certainly of adrenal hemorrhage are remarkably rare even when large doses of drugs have been employed. In my own experience, over 600 patients on long term steroid therapy have undergone major surgery without a single instance of adrenal failure.

2. Steroids do not cause peptic ulcer. Palmer and Kirsner[1,2] state, "lesions of the G.I. tract cannot be included in complications of steroid therapy" and "such conclusions are attributable to the *post hoc ergo propter hoc* fallacy."

3. The evidence for significant osteoporosis due to steroids is almost entirely based on extrapolation from Cushing's disease.[3]

My not inconsiderable experience since first employing Meticorten® (prednisone) in 1954 has convinced me that these and other side effects of steroids are more likely attributable to coincidence, too late initiation, too little, and too early discontinuation of treatment.

I have withheld expressing these views for publication because of their controversial nature until reading a news account of a successful malpractice action on the basis of some really novel effects attributed to cortisone. It seems that our chickens have really come home to roost. In this instance we cannot blame the juries or the attorneys but ourselves.

The profession will suffer in increased insurance rates but the real victims will be our patients. A recent article[4] was entitled, "Liability —MD's are Running Scared." If this continues it can well result in abandonment of medicine for homeopathy and naturopathy.

J. J. ROBBINS, M.D.
Hayward

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2. Cooke AR: Corticosteroids and peptic ulcer: Is there a relationship? Am J Digest Dis 12 (3):323-329, 1967
3. Saville PD: Osteoporosis And Corticoid Drugs (Editorial) Ann Int Med 73:1038, Dec 1970
4. Liability—MD's are running scared. Am Med News Apr 20, 1970

Unwilling Smoking

To the Editor: Soon after the 1964 report of the U.S. Surgeon General on the adverse effects of smoking on health, I began to appeal for a smoke-free indoor environment. I was gratified by the reference in the 1971 report of the Surgeon General to the adverse effects of ambient smoking. In the 1972 report,[1] a section is headed: Public Exposure to Air Pollution from Tobacco Smoke. This section is a powerful answer to critics who allege inconsistency and lack of proper control of statements by the Surgeon General; the presentation not only is a thorough account of available publications, but is notably impartial, and one could never know, from the discussion, which of the quoted articles originated from an agency supported and controlled by German tobacco interests.

The summary of the stated discussion deserves quoting in full.

"1. An atmosphere contaminated with tobacco smoke can contribute to the discomfort of many individuals.

"2. The level of carbon monoxide attained in experiments using rooms filled with tobacco smoke has been shown to equal, and at times to exceed, the legal limits for maximum air pollution permitted for ambient air quality in several localities and can also exceed the occupational Threshold Limit Value for a normal work period presently in effect for the United States as a whole. The presence of such levels indicates that the effect of exposure to carbon monoxide may on occasion, depending upon the length of exposure, be sufficient to be harmful to the health of an exposed person. This would be particularly significant for people who are already suffering from chronic bronchopulmonary disease and coronary heart disease.

"3. Other components of tobacco smoke, such as particulate matter and the oxides of nitrogen, have been shown in various concentrations to adversely affect animal pulmonary and cardiac structure and function. The extent of the contributions of these substances to illness